

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10318

CERTIFICATE OF DEATH

Reg. Dist. No. 251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County..... Queen Anne's
City or town..... Millington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry Bottomley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Sept 14 1873
..... (c) If alive, give age..... years

8. AGE: Years 72 Months Days
..... It less than one day
..... hrs. min.

9. Birthplace..... Millington Kent Md.
(Town, County, and state)

10. Usual occupation..... Farm Labor

11. Industry or business

FATHER 12. Name..... John Bottomley

MOTHER 13. Birthplace..... England

14. Maiden name..... Martha Baily

15. Birthplace..... Delaware

16. Informant..... Mrs. Harry Bottomley

Address..... Millington Md.
Burial Date thereof Nov 1, 1940

17. (Burial, cremation, or removal. Which?) Cemetery or crematory..... Millington

Location..... Millington Md.

18. Funeral director..... Edward Eller

Address..... Millington Md.

19. Oct. 31 1945 (Date rec'd by registrar) C. L. Lane

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Queen Anne's
City or town..... Millington
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27 1945 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 22 1945 to Oct. 27 1945

and that I last saw him alive on Oct. 26 1945

Immediate cause of death..... Arteria Reticularis

DURATION

Due to..... Auto accident

Due to..... Auto, Intestinal Obstruction

Other conditions..... Appendicitis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Harry Bottomley M. D. or other

Address..... Millington Md. Date signed Oct 31 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

152

CERTIFICATE OF DEATH

10319

Reg. D. I. A. No. 2572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Frederick Avenue
 County: Mt. Cheverreee
 City or town: Mt. Cheverreee
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

3. (a) FULL NAME Joseph Martin Brown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sarah Emma Weston Brown

7. Birth date of deceased (mo., day, yr.) Jan 8 - 1868 6. (c) If alive, give age 73 years

8. AGE: 77 Years 9 Months 13 Days If less than one day hrs. min.

9. Birthplace Frederick - Md
 (Town, county, and state)

10. Usual occupation Farming

11. Industry or business Joseph Brown
 MOTHER FATHER Harriett - Md

12. Name Joseph Brown
 13. Birthplace Harriett - Md

14. Maiden name Ida Harriett
 15. Birthplace Harriett - Md

16. Informant J. Paul Brown
 Address Cheverreee, Md

17. (Burial, cremation, or removal) Burial Date thereof Oct 24 - 45
 (month) (day) (year)

Cemetery or crematory Chestertield
 Location Cheverreee, Md

18. Funeral director Barton Brown
 Address Cheverreee, Md

19. 10-22-1945 Elie Armstrong
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Frederick
 City or town: Cheverreee
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. None
 (If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 - 1945 at 3:30 p.m.

CERTIFY that death occurred on the date above stated; that I attended deceased from

19. Oct 19 - 1945 to Oct 19 - 1945
 and that I last saw h. alive on Oct 19 - 1945

Immediate cause of death He was found dead on
front porch -
due to: From Circumstances would say
Cardiac attack.

Duration 1 day

Due to Cardiac attack

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. None

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

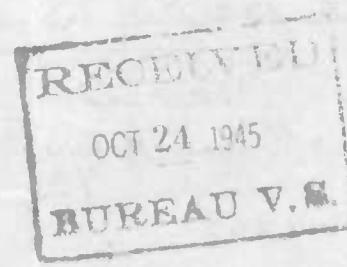
Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) None (County) None (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE W. Henry Fisher
 Address Chestertield Cor. Fisher 10-22-45
 Date signed 10/22/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

CERTIFICATE OF DEATH

10320

Reg. Dist. No.

251

1. PLACE OF DEATH:

County

City or town

Ducane Annex
Baltimore 157-20

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

Baby Clough

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

1

hrs.

min.

9. Birthplace

Baltimore 157-20

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Harry Clough

13. Birthplace

Maryland

14. Maiden name

Adrey Holloway

15. Birthplace

Maryland

16. Informant

Mrs. Harry Clough

Address

Budlerswell 157-20

17. Burial

Date thereof

Oct. 31, 1945

(month) (day) (year)

Cemetery or crematory

Home

Location

near Millington Ind.

18. Funeral director

G. L. Clough

Address

Millington Md.

19. Oct. 31, 1945

C. L. Lane

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 30th

1945, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 29th 1945, to Oct 30th 1945and that I last saw him alive on Oct 30th 1945

Immediate cause of death

Suffocation of
Heart Failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

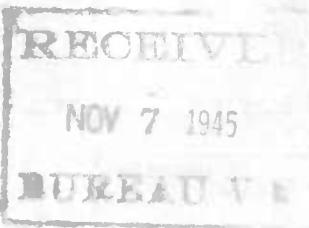
G. L. Clough M.D.

M. D. or other

Address Millington

Date signed Oct 30th 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *7-2*

10321

CERTIFICATE OF DEATH

Reg. Dist. No. *252*

1. PLACE OF DEATH:

County

Queen Anne's

City or town

Centreville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Wilberthe Evergreen Fleetwood

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female**white**widowed*

6. (b) Name of husband

Grace Welton Fleetwood

7. Birth date of deceased (mo., day, yr.)

February 20 - 1871

6. (c) If alive, give age .. years

8. AGE:

Years

Months

Days

If less than one day

74

8

4

hrs.

min.

9. Birthplace

Queen Anne's Co. Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

William Martin Evergreen

12. Name

Maryland

13. Birthplace

Sarah Eby with Callaway

14. Maiden name

Maryland

15. Birthplace

Chesapeake

16. Informant

Mrs. Dorothy Fleetwood

Address

Centreville Maryland

17. Burial

Cemetery

(Burial, cremation, or removal)

(Which?)

Date thereof .. *Oct 27-1945*

(month)

(day)

(year)

Cemetery or crematory

Chesterfield

Location

Centreville Maryland

18. Funeral director

Bailey Bear

Address

Centreville Maryland

19. (Date reg'd by registrar)

Oct 26-1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland Queen Anne's

City or town

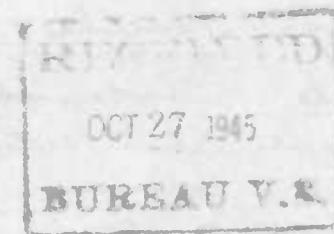
Centreville

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war...

(If rural, give LOCATION)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3021

10322

CERTIFICATE OF DEATH

Reg. Dist. No. 352

1. PLACE OF DEATH:

County.....

Queen Anne County

City or town.....

Queen Anne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 years

Hospital, institution, or street address where death occurred:

How long in hospital or Institution?.....

3. (a) FULL NAME

Eli Harris

4. Sex

m

5. Color or race

Coe

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

1895

B. (c) If alive, give age..... years

8. AGE:

Years
50.

Months

—

Days

—

If less than one day

hrs. min.

9. Birthplace.....

James City

- 76.6 (Town, county, and state)

10. Usual occupation.....

Farming

11. Industry or business

not known

12. Name.....

not known

13. Birthplace.....

76.6

14. Maiden name.....

not known

15. Birthplace.....

76.6

16. Informant.....

Address

Buried

(Burial, cremation, or removal. Which?)

Date thereof 10-15-45

Cemetery or crematory.....

James City

Location.....

76.6

18. Funeral director.....

J. Virgil Emerson & Son

Address

Denton Rd

19. 10-11-45

1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Queen Anne County

City or town.....

Queen Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Oct 10 1945

2d. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1941 to October 1945

and that I last saw h. in alive on October 9 1945

Immediate cause of death Myocardial

failure

DURATION 2 weeks

Due to Aortic lesions

and coronary arteritis years

Due to

Tubes

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

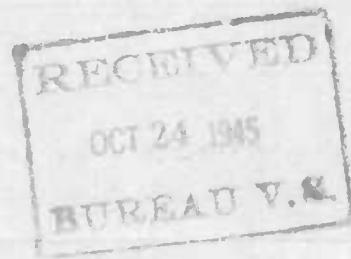
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Kurt Lederer M.D. M. D. or other

Address Date signed





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-1

10324

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

County Ocean AnneCity or town Queenstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all of life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John B. Pinder

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife John B. Pinder7. Birth date of deceased (mo., day, yr.) May 14 18666. (c) If alive, give age 65 years8. AGE: Years 79 Months 5 Days 8 If less than one dayhrs. 0 min. 09. Birthplace Kent Co. Md.

(Town, county, and state)

10. Usual occupation Laborer11. Industry or business Farm12. Name William Pinder13. Birthplace Kent Co. Md.14. Maiden name Unknown15. Birthplace "16. Informant John B. PinderAddress Queenstown, Md.17. Burial Burial Date thereof Oct. 21 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chesterfield CemeteryLocation Centerville, Md.18. Funeral director John D. WilliamsAddress Boston, Md.19. Oct 20 45 Date rec'd by registrar Helen M. Aldridge

Loc. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County OceanCity or town Queenstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

217-16-4325

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 45 1945, et 10 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct. 2 45 to Oct 19 45 1945and that I last saw h. John B. Pinder alive on Oct 12 45 1945

Immediate cause of death

PneumoniaDue to UnknownDue to Unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

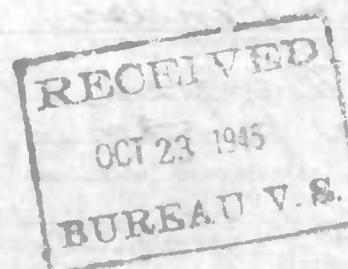
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Westover M. D. or otherAddress Queenstown, Md. Date signed Oct 20 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 240

CERTIFICATE OF DEATH

Reg. Dist. No. 253

5/25/325

1. PLACE OF DEATH: *Green Arrow*
 County: *Chester*

City or town: *Chester*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME *John J. Price 3rd*

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	—

6. (b) Name of husband or wife:.....

7. Birth date of deceased (mo., day, yr.) *Sept 9 1942*

8. AGE: Years *3* Months *1* Days *4* If less than one day

9. Birthplace *Baltimore* (Town, county, and state) *Md*

10. Usual occupation:.....

11. Industry or business

MOTHER FATHER *John J. Price*

12. Name *John J. Price*

13. Birthplace *Stevensville*

14. Maiden name *Evelyn Quimby*

15. Birthplace *Talbot Co*

16. Informant *John J. Price*

Address *Chester*

17. Burial Date thereof *Oct 15/45*
 (Burial, cremation, or removal (which?) Date thereof (month) (day) (year)

Cemetery or crematory *Stevensville*

Location *Stevensville*

18. Funeral director *Maurice Ellerquist & Son*

Address *Easton Md*

19. 10/14/45 1945 Date rec'd by registrar

J. C. Thomas Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State *Maryland* County *Queen Anne's*

City or town *Chester*
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war:.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 13 1945* at *5:10 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept. 1 1945* to *Oct. 13 1945*, and that I last saw him alive on *October 13 1945*.

Immediate cause of death: *Myeloid Leukemia*

Due to: *about 3 months*

Due to: *about 3 months*

Other conditions: *about 3 months*

(Include pregnancy within 3 months of death)

Major findings of operations: *about 3 months*

Date of op. *about 3 months*

Autopsy results: *about 3 months*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of: *about 3 months*

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: *about 3 months*

Injured at work? *about 3 months*

23. SIGNATURE *Reuter Settelewier M.D.*

M. D. or other *about 3 months*

Address *Stevensville*

Date signed *10/13/45*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

10326

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County..... Queen Anne

City or town..... Centreville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... all his life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Abe Roger

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male colored widowed

Alberta Bowers

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

April 12-1882

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

63 5 23

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Centreville, Queen Anne Co. Md.

10. Usual occupation.....

Laborer

11. Industry or business.....

House Cleaning

12. Name.....

William Roger

13. Birthplace.....

Centreville, Maryland

14. Maiden name.....

Laura Chamberlain

15. Birthplace.....

Centreville, Maryland

16. Informant.....

Bertha P. Trusty

Address.....

Centreville, Maryland

17. Burial.....

Date thereof..... Oct 9-45

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Chestertield

Location.....

Centreville, Maryland

18. Funeral director.....

Barton T. Jr.

Address.....

Centreville, Maryland

19. 10-9-1945

(Date rec'd by registrar)

Elise Armstrong

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Oct 6.

1945 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18.

to

19.

and that I last saw h..... alive on

10.

Immediate cause of death.....

He died during an

DURATION

Due to.....

Epileptic Convulsion

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

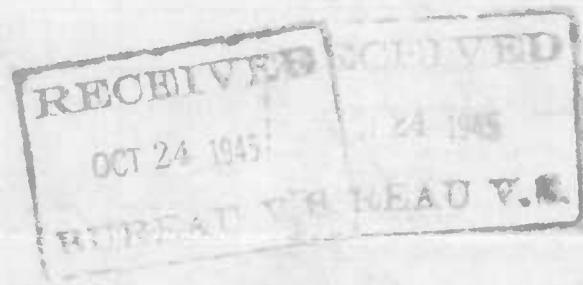
W. J. Fisher
deputy medical examiner

M. D. or other

Centreville, Md.

Oct 9-45

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *26*

CERTIFICATE OF DEATH

10327

Reg. Dist. No.

251

1. PLACE OF DEATH:

County *St. Marys Co.*City or town *Rehoboth*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 years*Hospital, institution, or street address where death occurred: *Rehoboth*How long in hospital or institution? *2 days*

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Lavinia Stanbury

7. Birth date of deceased (mo., day, yr.)

Feb. 8 - 1873

6. (c) If alive, give age

63 years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county and state)

10. Usual occupation

Farm laborer

11. Industry or business

MOTHER FATHER

12. Name *James O. Stanbury*

13. Birthplace

Maryland

14. Maiden name

Augusta Elliott

15. Birthplace

Maryland

16. Informant

Mrs. Lavinia Stanbury

Address

Buckley Ind.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *Oct. 29. 1945*

(month) (day) (year)

Cemetery or crematory

Buckley Col. Cem.

Location

Buckley Ind.

18. Funeral director

Edgar L. Lane

Address

Church Hill Ind

19. Date rec'd by registrar

Oct. 26 1945

C. L. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

City or town *Rehoboth*County *St. Marys Co.*

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 25 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 22 1945 to *Oct 25 1945*and that I last saw him alive on *Oct 23 1945*

Immediate cause of death

Heart Disease

DURATION

Due to

Due to

Other conditions

Prostate

6 mos

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *✓* Date of

Where did injury occur? (City or town) (County) (State)

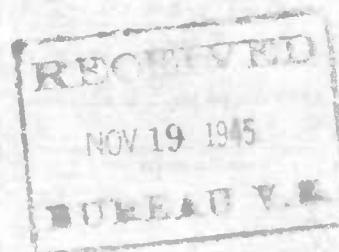
Injured at home, farm, industry, public place (where?) *✓*Means of injury *✓* Injured at work? *✓*

23. SIGNATURE

Edgar L. Lane

M. D. or other

Address *Church Hill Ind* Date signed *Oct 26 1945*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

County

Belleville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

all of life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James B. Stewart

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored Widowed

8. (b) Name of husband or wife: Florence Stewart Deceased

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

Nov 18 1887

8. AGE:

Years

Months

Days

If less than one day

57 10 17 hrs. min.

8. Birthplace

(Town, County, and state)

10. Usual occupation

Laborer

11. Industry or business

Road Work

12. Name

James B. Stewart

13. Birthplace

Belleville Md

14. Maiden name

Julia Biffle

15. Birthplace

Belleville Md

16. Informant

Dewey Griffith

Address

Belleville Md

17. Burial

Date thereof

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Belleville A. M. Cemetery

Location

Belleville Md

18. Funeral director

John D. Jefferson

Address

Belleville Md

19. (Date rec'd by registrar)

10-8-45 Helen M. Reddinger

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Queen Anne

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 10328 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

218-81-6386

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 5, 1945

CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 30 1945 to Oct 5, 1945

and that I last saw him alive on Aug 30 1945

Immediate cause of death

For advanced Relational
Paroxysms

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

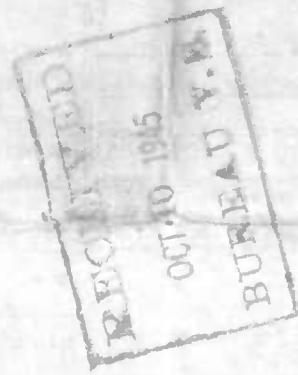
23. SIGNATURE

C. R. Layton M.D.

M. D. or other

Address

Centreville Md Date signed Oct 6, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

CERTIFICATE OF DEATH

10329
Reg. Dist. No. 251

1. PLACE OF DEATH:

County.....

Queen Anne

City or town.....

Sudlersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Hausilla D. Weedman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife.....

Denver D. Weedman

7. Birth date of deceased (mo., day, yr.)

Nov. 24 - 1884

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Queen Anne Co. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

James D. Wilson

12. Name.....

MOTHER FATHER

G. A. Co. Md.

13. Birthplace.....

14. Maiden name.....

Martha Jennie Nunbracco

15. Birthplace.....

G. A. Co. Md.

16. Informant.....

Mrs. Wilson Weedman

Address

Sudlersville Md.

17. Burial

Burial

(Burial, cremation, or removal. Where?)

Date thereof Oct. 18-1945

(month) (day) (year)

Cemetery or columbarium.....

Sudlersville

Location.....

Sudlersville Md.

18. Funeral director.....

Edgar L. Lane

Address

Church Hill Md.

19. Oct. 16

1945

(Date rec'd by registrar)

Edgar L. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Queen Anne

City or town.....

Sudlersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Oct 15

1945

at

3:10

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 15

1945

to

1945

and that I last saw her alive on

Oct 15

1945

1945

Immediate cause of death.....

Pneumonia

DURATION

Pneumonia

Died of.....

Pneumonia

DURATION

Due to.....

Pneumonia

DURATION

Other conditions.....

(Including pregnancy within 8 months of death)

DURATION

Major findings or operations.....

—

DURATION

Autopsy results.....

—

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

—

Injured at work? —

23. SIGNATURE.....

Edgar L. Lane

M. D. or other

Address.....

Sudlersville Md.

Date signed

Oct 16 1945

RECEIVED TO THE EAST COAST GUARDIAN

TELETYPE FACSIMILE

RE

OCT 23 1945

BUREAU V.R.

10/14/54